C O R R E C T E D V E R S I O N

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

LEGISLATION COMMITTEE

Inquiry into the performance of the Australian Health Practitioner Regulation Agency

Melbourne — 4 September 2013

Members

Ms G. Crozier	Mrs A. Millar
Mr N. Elasmar	Mr D. O'Brien
Ms C. Hartland	Mrs I. Peulich
Ms J. Mikakos	Mr M. Viney

Participating member

Mr A. Elsbury

Chair: Ms G. Crozier
Deputy Chair: Mr M. Viney

Staff

Secretary: Mr R. Willis

Witnesses

Mr G. Taylor, chief executive officer, Nursing and Midwifery Health Program Victoria; and

Associate Professor D. Heinjus, director of nursing, Royal Melbourne Hospital.

The CHAIR — I welcome Associate Professor Denise Heinjus, director of nursing at the Royal Melbourne Hospital, and also Mr Glenn Taylor, chief executive officer of the Nursing and Midwifery Health Program Victoria. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Legislative Council standing orders.

All evidence is being recorded. You will be provided with proof versions of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website. Thank you for the submission you have provided to the inquiry. I now invite you to proceed with a brief presentation to the committee, to be followed by questions from members. Again, welcome to you both.

Mr TAYLOR — Thank you very much for the opportunity to appear. I understand that you have in front of you the submission, so I will touch on some other factors which I have not included in the submission, if that is okay.

The CHAIR — Thank you.

Mr TAYLOR — The Nursing and Midwifery Health Program Victoria was established in August 2006. I am pleased to inform the committee that we were advised by the Nursing and Midwifery Board of Australia on 2 September — last Monday — of the decision to grant the program a two-year funding extension, which will take us up until June 2016. The program is a free, independent and confidential support service for nurses, midwives and students of nursing and midwifery in Victoria. It was designed by nurses, it is governed largely by nurses, it is administered by a nurse and the services are provided by nurses. The organisation offers regional-based services in addition to our metropolitan-based service.

The organisation came about through the work of some interested nurses back in the early 2000s, with the ANF Victoria branch, the former Nurses Board of Victoria and research undertaken by Dr Cally Berryman. Dr Berryman identified significant barriers to health seeking for nurses and midwives, which include fear, guilt, shame, isolation and loneliness. Presenting issues that we see include addiction to substances and a high prevalence mental health concerns. The majority of our participants present with health concerns which are in some way related to their work in the profession. The make-up of our referrals includes self-referrals, which are approximately 90 per cent; what we call employer-assisted referrals, which are approximately 5 per cent; and what we call AHPRA referrals, which are approximately 5 per cent. The majority of our referrals come through the Australian Nurses and Midwifery Federation Victoria branch, the individual themselves, their employer, AHPRA, their family, friends or colleagues.

According to the data we have collected to date — as of the end of August this year — which commenced in August 2006, we have opened 1082 cases of care and episodes of care, of which approximately two-thirds are mental health presentations. Those predominantly include anxiety and depression, so the high-prevalence disorders. Approximately a third are substance abuse concerns. The majority of those will be alcohol, and opiates would be second. Approximately 36 per cent of participants identify as living and/or working outside of metropolitan Melbourne.

We enjoy universal support. The program is recognised internationally for the model and the outcomes it achieves. We have been the subject of a two-year independent research project conducted by the University of Melbourne and an estimated economic benefits analysis undertaken by Monash University in 2011. Both of these pieces of research presented the service favourably. We participated in an NMBA-commissioned study conducted by Professor Ian Siggins in 2012 called *Evaluation of Health Programs for Managing Impaired Nurses and Midwives*. The report was positive in relation to the NMHP model and the role we play in Victoria.

The NMHP has convened two wellness conferences that have attracted approximately 900 delegates on each occasion. We have become an integral part of the nursing and midwifery landscape of Victoria, and we have developed a strong goodwill and supporter base. We are currently leveraging this goodwill and offering what we call an NMHP champion training program. That involves skilling up those volunteers or supporters who are nurses and midwives out in the field in our history, our purpose and our model and supporting them to go out and support and promote our program in their organisation. I might leave that there for the moment and take any questions that you have.

The CHAIR — Certainly. Would you like to add anything, Professor Heinjus?

Assoc. Prof. HEINJUS — No.

The CHAIR — I go to the point that you raised just now in relation to the extension to the funding. I think you said that came through on 2 September, just this week. Funding has been provided up until 30 June 2016 — is that correct?

Mr TAYLOR — That is correct.

The CHAIR — So after that point you do not have any secure funding. That is correct?

Mr TAYLOR — That is correct.

The CHAIR — Right. What would happen if there were a change to the board? Would that put that funding up until 2016 at risk?

Mr TAYLOR — A change in the national board?

The CHAIR — Yes. If the board were to change or if the state boards were rolled and had a more national focus, so if there were a change at that level, would that put the funding for the Victorian program at risk?

Mr TAYLOR — Theoretically I suppose it would. However, I imagine we would be signing contracts that would hold both parties to account. My understanding is that part of the rationale for the two-year period is to give the national board an opportunity to do some research around what might look like a suitable or ideal national model. I imagine those sorts of things take time. It would probably take every bit of that time frame.

The CHAIR — Have you signed the contracts as yet?

Mr TAYLOR — No. The ink is still drying on the offer. We are still celebrating.

The CHAIR — Okay. Very good.

Ms MIKAKOS — Thank you for clarifying the funding situation. I want to ask you now about the evaluation. You said you had a Monash University evaluation in 2011. Are we able to get the findings from that?

Mr TAYLOR — Certainly. I can send those to you.

The CHAIR — Yes, if you wouldn't mind. Send it to the committee secretary.

Mr TAYLOR — Would you like me to give you some of the key — —

Mrs PEULICH — Give us a handful.

The CHAIR — If you have them with you.

Mr TAYLOR — I think I brought them with me. I will just summarise the outcomes for you, if that is okay. By way of background, this research was based on 496 individuals who, at this particular time, which was from August 2006 to the end of July 2011, had come through our service. The findings from the economic estimates were that a nurse with substance abuse and/or mental health problems who has time off work costs on average $52 000 to $70 000 by way of lost productivity. This is assuming a like-for-like replacement; however, agency nurses, who are usually the ones who cover that, we know cost more. This nurse also returned to work. This was in the presence of our support — the Nursing and Midwifery Health Program support. Without such a service there is a likelihood that they may have left nursing entirely, further exacerbating the shortage of qualified nurses.

A nurse with problems who does not have time off work but instead has conditional employment costs on average $38 000 to $40 000. For those who went through our program, this represents a direct cost saving or benefit of the program of $7.23 million to the health sector — that is extrapolated out based on the data we provided — or $4.29 million to the public health sector. I can provide these details. There are further benefits that have not been valued, like improved health and wellbeing of nurse work conditions, such as less pressure, stress on other nurses, continuity of care for patients and general collegial support.

Ms MIKAKOS — Were there any findings in relation to whether there seems to be a concentration of issues — anxiety, for example — in particular classes of nurses, such as those working in emergency departments or aged-care facilities or agency nurses? Have you got any findings in relation to any of those particular types of issues?

Mr TAYLOR — Yes, we do. I will just make the point that the Monash University document, which I just quoted from, was on economic estimates. We have had a University of Melbourne report which was done separately, which was a two-year report which looked at our qualitative and quantitative data. But in answer to your question, when nurses and midwives come to us we take their area of work details. The areas such as emergency departments, ICU and critical care are far and away the most common presenters. The second most common is mental health, and the third most common is aged care.

In the breakdown of that, not surprisingly the majority of the people that we see are women. The majority of women we see are over the age of 40 to 45, and it is fair to say that the majority of them are experiencing symptoms of prolonged stress and anxiety, workload, whether that be the work that they are doing within their paid employment or in their unpaid employment outside their work.

Ms MIKAKOS — When you say 'presenters', that could be any of those issues you talked about before like mental health issues or substance abuse issues.

Mr TAYLOR — Yes. That is right.

Mr O'BRIEN — Thank you again for coming tonight. I just wanted to pick up on something you touched on very briefly and ask you: how does your program reach in assisting rural and regional areas?

Mr TAYLOR — We were fortunate enough, prior to the demise of the former Nurses Board of Victoria, to acquire some additional funds to be able to recruit a person specifically to do that work — very fortunately. We promote on our website; we promote through presentations, conferences and our networks; electronically and in person. The work we are able to offer in regional areas is our worker going to our locations, which include Geelong, Ballarat, Bendigo and Traralgon. That is our attempt to cut a bit of time off the distance for people who are in further outlying areas, typically in rural settings. We know one of the barriers, apart from the fear, shame, isolation and guilt, is that if you have the only service in town, which you probably have an affinity with in some way or another directly or indirectly. That is a further barrier, and the chances of you accessing support for a problem are quite remote. We cycle around the state, so to speak, and in each week we will visit one of those locations. That is on our timetable. The nurses who require that support are appointed times within those days and those weeks, and they can come to us in those settings, or they can come to us in Melbourne if they choose to.

Mr O'BRIEN — Could you tell us, in your view, obviously objectively but from whatever evidence you have gained — hopefully from various surveys — what the benefits are of the model of the Nurses and Midwifery Health Program Victoria compared to alternative services?

Mrs PEULICH — In answering that question, could you outline or dot-point the features of your service and also the features of any alternate models?

Mr TAYLOR — Sure. We are the only service of our kind in the country. We are obviously the only service of our kind in the state. Strictly speaking, as far as we can ascertain, we are the only service of our kind in the world that works on this particular model. The selling points that we see for this program — and it was designed this way, because the research said that the barriers were such that we needed to counteract the barriers. So it needed to be free, which it is. It needed to be independent from employers, and it needed to be confidential. Nurses quite typically are sensitive about their information and needed to know that the sensitive information that they were going to disclose potentially to people like us was in safe hands. Those are the three things that we believe and we are told, and the research tells us, overcome those barriers.

In addition to that, and probably this is one of the most significant points, we are nurses, so we understand the industry as well as our participants or clients, as well as having the benefit of the expertise of alcohol and drug experience and mental health work. One of the complaints that I think recipients of care make is that they have to explain themselves; they have to go through the detail, and often it is for a third or a fourth or a fifth time. When they come and see us they tell us that they do not have to explain the nuances of the nursing or midwifery

industry. We understand what it is like to be a graduate who is wet behind the ears and who is feeling intimidated by that 35-year veteran. We understand what it is like to run units. We understand what it is like to witness and experience bullying and those types of things. All that unspoken stuff does not have to be said, and that is what we are told breaks down those barriers. The employer assistance program services, and the Siggins report identified these as being alternatives to our service — to this model.

Mrs PEULICH — We have moved to the alternatives. I am still trying to get my mind around what you do. Do you provide counselling, advice, treatment?

Mr TAYLOR — We provide counselling. We call ourselves a safe entry point into the service system. We are not going to be able to provide everything to everyone, but what we can do is provide you with a safe place to come and start to disclose potentially the most horrific of circumstances that no other human has heard and they could not ever imagine telling anyone. They will come and disclose that to us. Now most of the people we see we are able to hold and to case manage and to support. But certainly if it is outside of our scale, then we have a trusted source of referrers who we can refer them to. They might include psychiatrists, psychologists, addiction medicine specialists, sensitive GPs — those sorts of people.

We work on a strength-based, problem-solving model. It is about working with the client or participant to identify what their strengths are, to build on the strengths, identify what their risks or weaknesses are, to try to minimise or reduce those so that then they can start to take some control of their lives. They develop their care plan, we write up the care plan and they sign off on that care plan. A lot of them like it, because it holds them to account, and it is like a binding contract for them so that they feel obliged to follow it through and activate the strategies on their care plan.

Mrs PEULICH — Have you costed that service per nurse, or is there a number of sessions they attend? What would be the average experience? Obviously it is going to be variable from case to case, but is there a cost for it?

Mr TAYLOR — Is there a cost? No, there is no cost involved.

Mrs PEULICH — No, no. There is a cost of providing the service. They may not pay it, but there is obviously a cost.

Mr TAYLOR — Our funding against the number of nurses and midwives in this state works out at less than $6 per nurse.

Mr O'BRIEN — Can I just ask you something on confidentiality. You touched on it in that final question. I — —

Mrs PEULICH — Sorry, no, he has not finished on the alternative models.

The CHAIR — Could you finish your point on the alternative models, and then I will move back to Mr O'Brien. Just finish off on the alternative models if you could, and I will move back to Mr O'Brien before going to Mrs Millar.

Mr TAYLOR — The Ian Siggins piece of work was about identifying alternate support models to ours. As far as I can ascertain, what Professor Siggins was able to find was that employment assistance programs were the only alternate model. Now, we promote employment assistance programs to our nurses and to nurses generally as another alternative because we do not believe that we are the right model for everybody. But as I understand it, and being a recipient of those in the past, they are contracted by my employer if I work for a particular health service. They are time limited, and the service is usually provided by a psychologist and generally not a nurse. So there is a range of differences there.

Mr O'BRIEN — I just wanted to take you back to that question. You touched on confidentiality. One of our terms of reference, or a key plank of our terms of reference, is protection of the public. Have you identified or can you identify any risks of underreporting as a result of the changes to the new regime and concerns you might have over confidentiality and mandatory reporting?

Mr TAYLOR — Myself and my two colleagues who work in this capacity, we are all nurses, and we are mandated — as is every other nurse in this country — to report if we believe that nurses or midwives are a risk

to the public. We hold that higher than anything. We have not actually made any notifications to AHPRA prior to or since the new scheme came into effect, but we have insisted on and supported some nurses and midwives to self-report, self-notify. We take a very sensitive approach to it even when people are clearly in need of being notified, because we view it from a health perspective. We walk them through. From the moment they walk through the door we advise them of what our obligations are in terms of mandatory reporting and working within the scheme. So they are very clear about what position they are walking into. To my surprise, the majority of the people who have disclosed that to us have been relieved to be free of the burden and to have purged themselves of the concern that they have, and in some way they have been grateful for the opportunity to self-notify. So not only does this program support the individual but it also does work in accordance with the scheme to protect the public.

Mr O'BRIEN — You have set out concerns on page 2 in relation to your concern that:

> AHPRA will no longer have access to the 'conditional support' we offer impaired nursing and midwifery registrants.

You say it is an essential role. Can you outline why you consider that role to be important in protecting the public and what concerns you have?

Mr TAYLOR — Sorry, can you just point me to the paragraph, if you do not mind?

Mr O'BRIEN — It is the last paragraph on page 2.

Mr TAYLOR — Sure. A number of nurses who come to the attention of the board through AHPRA, who have notified, ultimately require some conditions on their registration. At the moment, and since the new scheme commenced, a number of nurses have required external support and supervision and conditional monitoring, and we are part of that at the moment. So it is not uncommon in the findings of the board to say one of the conditions is that that nurse needs to be under our care and seek our support. We are then requested by the board and permission is given by the nurse to provide reports to the board on their progress as far as their treatment goes. So it is one of our observations that if we were to disappear, then that would no longer be an option. However, I do understand that there could be some other alternatives which AHPRA may be looking into in that regard. But currently we have a number of nurses who we are seeing and continuing to support and writing reports to AHPRA and the board for.

Mr O'BRIEN — Which model is best in terms of protecting the public, your continuing role as you see it or some other model that AHPRA might be scheming up?

Mr TAYLOR — From my point of view, and I am incredibly biased I suppose — —

Mr O'BRIEN — It is hard to be objective sometimes, but we need your evidence, if you could.

Mr TAYLOR — We are a very small team who hold the credibility and the integrity of the organisation very highly. We are in the business of promoting and supporting the health of the individual but at the same time not putting the public at risk. We believe that the systems and mechanisms and processes that we have in place are able to provide adequate support to that person and to their commitment to their recovery or to their wellness. Whilst there is always I suppose potential for that to fall down, we believe that the system that we provide is quite a successful one.

Mrs MILLAR — I think my question goes to a similar area to Mr O'Brien's. Referring to some of the comments you have made in your submission about your relationship with AHPRA and how that may potentially impact on your service into the future, what would you see as the optimal relationship between yourself and that body, particularly pertaining to your viable future as an organisation?

Mr TAYLOR — AHPRA has probably been a little bit unfortunate to have inherited us. Our constitution is such that we have two members. One is now called Australian Nurses and Midwifery Federation, formerly the ANF Victorian branch, and our other inaugural member was the Nurses Board of Victoria. With the demise of the Nurses Board of Victoria the logical member to replace the board was AHPRA. I can sort of empathise with AHPRA in that respect, because it is a national body that regulates over a dozen professions.

I can certainly empathise with the question in 2010, 'What the hell is the program and what is our responsibility to it?'. I just need to be very clear about the relationship. I understand, I think, AHPRA's role in the world — in

our world — and the relationship is very clearly, in my opinion, between us and the board, so that is the national board or the state board of the national board. We have a very strong and supportive relationship with AHPRA currently, but as I understand it is not AHPRA's responsibility to be having those negotiations. It is actually that we see our relationship is with the board. In an ideal world where the Victorian board at the time took the decision to provide the funding for this program through Victorian nurse registration, we would ideally like to see that continued, obviously from the national board, but that there be some mechanism set in place so that a portion of Victorian nurses registration could come to this program for Victorian nurses and midwives.

The CHAIR — Can I ask, in relation to that decision that was handed to you two days ago, was that through lobbying from you to extend that program? How did that occur?

Mr TAYLOR — Incredibly difficult and long-term lobbying, which dates back to prior to the national scheme commencing.

The CHAIR — So it is a significant issue for this program to continue having funding?

Mr TAYLOR — Correct. That was a significant decision and outcome. We took a decision, a very measured decision, in 2010 before the national scheme commenced that Victorian nurses and midwives are not the only nurses and midwives who have these types of sensitive health issues. This model can be replicated, not necessarily in an exact form because Victoria is a very different state to WA or to Queensland or to the Northern Territory, but the principles that this program operates under are transferable. We strongly believe that nurses in outback WA have the same issues as nurses in central Melbourne and that they can get the same type of support and need the same type of support. So we would ideally like to see — —

We want to survive in Victoria first and foremost. We think it would be terrific.

Ms MIKAKOS — You want to go national?

Mr TAYLOR — I would like to see the 330 000-odd nurses and midwives around the country have access to a program such as this, because currently they do not.

The CHAIR — Well done on your work. I do not believe there are any further questions.

Mrs PEULICH — Sorry, just one last question, if I may?

The CHAIR — Yes, Mrs Peulich.

Mrs PEULICH — You mentioned earlier that the cost of the service you provide works out to be approximately $6 out of the registration fee. For the number of nurses who access your service what is the average cost, rather than spreading it across the entire membership?

Mr TAYLOR — The entire state?

Mrs PEULICH — Yes.

Mr TAYLOR — We see anywhere between — I think last year we saw approximately 210 individuals, so it is a budget of half a million.

The CHAIR — Do the maths.

Mr TAYLOR — I am not too quick on the maths in this situation. If I could just refer back to the Monash University estimates, I was staggered when I saw those figures. I thought there were misprints there when they were talking about saving — extrapolated figures, but saving — into the millions of dollars. We know, and Denise as a director of nursing knows, the time and effort and resources it takes to recruit, to train, to orientate, to support and to grow a nurse in an organisation. We do not want to lose them. With respect to the resource that goes out the door after 5, 10, 15, 20, 25 years, it is criminal that that sort of intelligence and that sort of experience has been lost to the industry.

Ms MIKAKOS — Chair, just one question, if I may?

The CHAIR — A final question.

Ms MIKAKOS — Just because we have been talking about costs and the number of people assisted, I refer to your earlier evidence where you said that that you had organised two wellness conferences. Could you elaborate a little bit about preventive strategies that your organisation undertakes?

Mr TAYLOR — Sure. A very strong feature of the organisation from day one was for my predecessor to go out and visit anyone and everyone who would listen about this program. It would be everyone from directors of nursing down to students in universities. It was about promoting and publicising the program and what it did and how you could access it. What has evolved, probably three or four years ago, is that we have realised that we cannot keep on going back to organisations and saying, 'This is the NMHP, this is what we do', so we can add some value to that. So we developed programs, what we call health promotion and prevention programs, and we take them out with us.

We say, 'This is the NMHP and this is what we do, and by the way this is what you can do to support your own health'. We will run anything from a 15-minute session right through to a couple of hours, where we will educate the nurses and midwives and students about their own health concerns and the importance of their health not only to their patients and to their organisations but to their own families and relations, and to take that opportunity to leave a legacy out there. That is actually quite a bit of my work that I do. I do a lot of visits to those sorts of organisations — health organisations and universities — promoting this service and how they can look after themselves.

Assoc. Prof. HEINJUS — The fact that nearly 1000 nurses have turned up to two conferences titled 'A Wellness Conference' was a pleasant surprise to me. It is obviously filling a need. When talking to some of the nurses at the conference over lunch a few of them were saying, 'We would never miss this'. It has really been a highlight in their career to attend it. I was surprised. There is a message there for us.

Ms MIKAKOS — It certainly got my attention when you said 900.

Assoc. Prof. HEINJUS — Yes.

The CHAIR — Thank you. I do not believe there are any further questions, so on behalf of the committee I thank you both very much for appearing before us this evening and providing the evidence that you have. It has been most helpful; thank you very much indeed.

Committee adjourned.